Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MILLENNIUM LABORATORIES OF CA
16981 VIA TAZON
SAN DIEGO CA 92127-1645

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-0254-02

MFDR Date Received
September 24, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim for laboratory services was originally denied for ODG documentation requirements for Urine Drug Testing have not been met. On 05/03/12 required documentations was submitted to Texas Mutual Insurance Company as requested for review and reconsideration and it was denied on 06/12/12 stating original payment decision is being maintained."

Amount in Dispute: $755.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue involves Texas Mutual's inability to make a medical necessity determination because of a lack of documentation. Texas Mutual's principal denials in this dispute pertained to the lack of information (documentation) provided. As such it constitutes a fee documentation denial, not a medical necessity denial."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2011	Urine Drug Screening	$755.61	$381.34

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.210 sets out documentation requirements.
3. 28 Texas Administrative Code §137.100 sets out treatment guidelines.

4. 28 Texas Administrative Code §19.2015 defines words and terms pertaining to utilization review of health care.
5. 28 Texas Administrative Code §19.2015 sets out procedures for retrospective review of medical necessity.
6. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 758 – ODG DOCUMENTATION REQUIREMENTS FOR URINE DRUG TESTING HAVE NOT BEEN MET.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

Issues

1. Did the requestor meet documentation requirements?
2. Did the insurance carrier appropriately request additional documentation?
3. Did the insurance carrier follow the appropriate administrative process to address the assertions made in its response to the medical fee dispute?
4. Were Medicare policies met?
5. Is reimbursement due?

Findings

1. The respondent denied disputed services with reason codes CAC-16 – "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE;" 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION"; and 758 – "ODG DOCUMENTATION REQUIREMENTS FOR URINE DRUG TESTING HAVE NOT BEEN MET." The respondent's position statement asserts that "Texas Mutual's principal denials in this dispute pertained to the lack of information (documentation) provided." Documentation requirements for the services provided are not established by the Division's treatment guidelines as set forth in 28 Texas Administrative Code §137.100, related to the use of the *Official Disability Guidelines—Treatment in Workers' Comp* (ODG), published by Work Loss Data Institute; rather, the procedures for submitting and requesting documentation are established in 28 Texas Administrative Code §133.210, which describes what documentation is required to be submitted with a medical bill. For the services in dispute, §133.210 does not require documentation to be submitted with the initial medical bill. The Division concludes that the provider has met the documentation submission requirements of §133.210. The insurance carrier's denial reason is not supported.
2. In its response to this medical fee dispute, the insurance carrier cites the lack of clarifying information and/or documentation as a reason for denial of payment, stating "The issue involves Texas Mutual's inability to make a medical necessity determination because of a lack of documentation. Texas Mutual's principal denials in this dispute pertained to the lack of information (documentation) provided." The procedure for an insurance carrier to request documentation not otherwise required upon submission of a bill is specified in §133.210(d) as follows:

   Any request by the insurance carrier for additional documentation to process a medical bill shall:

   (1) be in writing;

   (2) be specific to the bill or the bill's related episode of care;

   (3) describe with specificity the clinical and other information to be included in the response;

   (4) be relevant and necessary for the resolution of the bill;

   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;

   (6) indicate the specific reason for which the insurance carrier is requesting the information; and

   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted information finds no documentation to support that the insurance carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The division concludes that the insurance carrier failed to meet the requirements of §133.210(d).

3. The insurance carrier's position statement asserts that "The issue involves Texas Mutual's inability to make a medical necessity determination because of a lack of documentation. Texas Mutual's principal denials in this dispute pertained to the lack of information (documentation) provided. As such it constitutes a fee documentation denial, not a medical necessity denial." Review of the submitted explanations of benefits finds no denial codes or explanations of reduction or denial of payment related to medical necessity. No documentation was found to support the existence of an unresolved issue of medical necessity prior to the date the request for medical fee dispute resolution was filed.

   Further, the Division notes that 28 Texas Administrative Code §137.100(e) sets out the appropriate administrative process for the insurance carrier to retrospectively review the reasonableness and medical necessity of disputed services. Section 137.100(e) states: "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Former 28 Texas Administrative Code §19.2003(28), effective June 1, 2003, 28 *Texas Register* 3965 defines retrospective review as "The process of reviewing health care which has been provided to injured employees under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary."
   Former 28 Texas Administrative Code §19.2015(b), effective June 1, 2003, 28 *Texas Register* 3965, titled *Retrospective Review of Medical Necessity,* states:

   > When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).

   Review of the submitted information finds no documentation to support that the insurance carrier followed the appropriate administrative process to address the assertions made in its response to this medical fee dispute.

4. 28 Texas Administrative Code §134.203(b)(1) states that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiative (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." §134.203(a)(5) states that "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, values and weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." The services in dispute are clinical laboratory services. Review of the submitted documentation finds that current procedure codes required by Medicare were billed. No CCI edit conflicts, Medicare billing exclusions, or medically unlikely edits were found to apply to the services in dispute. The Division concludes that the requestor has applied Medicare payment policies in accordance with the requirements of §134.203.

5. The services in dispute are eligible for payment. Per §134.203(e):

   > The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
   >
   > (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and
   >
   > (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

   CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a professional component; for that reason, reimbursement is determined according to §134.203(e)(1). The maximum allowable reimbursement (MAR) for the services in dispute is 125% of the fee listed for the codes in the Medicare 2011 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. Review of the submitted information finds that the provider sufficiently documented the units billed. Therefore, the total MAR is calculated as follows:

   - The fee listed for procedure code 80102 is $18.64. 125% of this amount is $23.30.
   - The fee listed for procedure code 80154 is $26.03. 125% of this amount is $32.54.
   - The fee listed for procedure code 80299 is $19.27. 125% of this amount is $24.09 at 2 units is $48.18.

- The fee listed for procedure code 81003 is $3.16. 125% of this amount is $3.95.
- The fee listed for procedure code 82145 is $21.87. 125% of this amount is $27.34.
- The fee listed for procedure code 82520 is $21.33. 125% of this amount is $26.66.
- The fee listed for procedure code 82570 is $7.28. 125% of this amount is $9.10.
- The fee listed for procedure code 83789 is $25.41. 125% of this amount is $31.76.
- The fee listed for procedure code 83805 is $24.80. 125% of this amount is $31.00.
- The fee listed for procedure code 83840 is $22.98. 125% of this amount is $28.72.
- The fee listed for procedure code 83925 is $27.38. 125% of this amount is $34.22 at 3 units is $102.66.
- The fee listed for procedure code 83986 is $5.04. 125% of this amount is $6.30.
- The fee listed for procedure code 84311 is $9.83. 125% of this amount is $12.29. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $9.83.

The total allowable reimbursement for the services in dispute is $381.34. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $381.34. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $381.34.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $381.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 20, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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